

TALLEY AND CREWS RESPOND

Caregiving across the lifespan is a vital public health concern. The very personal nature of caregiving makes it a complex and often intimate process, with continual change in its nature and type. The caregiving process encompasses myriad facets. Although care is given to an individual, the caregiving process frequently involves multiple providers and occurs within interactive, dynamic contexts of varying durations and incredible delicacy.^{1–3} Historically, health professionals and family members have viewed caregiving as an aging issue; today, however, there is increasing attention to caregiving's effects on children and adolescents as well as adults, including those with disabilities.⁴

As Eckenwiler notes, the changing caregiving context, or the ecology of care dynamics, settings, and participants, imposes an important backdrop for care decisions. For instance, for both the caregiver and care recipient, aging, disease progression, care duration, and medical, social, and familial support networks influence when, how, and by whom care is provided. In addition to the physical strain that often accompanies caregiving, emotional health also can be compromised, although many caregivers have reported the care experience to be meaningful and rewarding. Within the dyadic context of the caregiver–care recipient relationship, there exists a

constant tension between the caregiver's abilities, willingness, and feelings about providing care and the care recipient's abilities, attitudes, and emotions about receiving it. These do not occur in a vacuum; indeed, the ecology of the family and environment are prominent considerations.

Assessment, policy development, and assurance are the cornerstones of public health.⁵ The nation is beginning to apply these constructs to caregiving. For example, although there are estimates of the numbers of caregivers in the United States, no state-level population-based statistics are currently available. To meet this public health assessment need, the Centers for Disease Control and Prevention developed a caregiver module for the Behavioral Risk Factor Surveillance System that will likely be available to states in 2009. By adopting the module, states will be able to determine the number of caregivers within their boundaries and identify crucial needs. The caregiver module has been field-tested in North Carolina,⁶ and further research is occurring in Hawaii, Kansas, Rhode Island, and Washington. Data from the module can be used to develop state plans, encourage caregiving research, target interventions, and initiate policies that can be crafted into legislative language. The Centers for Disease Control and Prevention will aggregate the data into a national report to inform officials and policymakers at all levels. Public health assurance will extend this process to include participation in recruiting a competent workforce; providing care linkages; and evaluating legislative outcomes, such as those produced by the National Family Caregiver Support Program.

As the public health of caregiving advances as an important lifespan issue, educators, public health officials, policymakers, and advocacy organizations need to continue to identify caregivers, analyze issues, and implement solutions.⁷ As Lee stated, "The challenge for public health systems is to develop a strategy for reaching out to all Americans that is sensitive to the complexities of caregiving." We believe public health is up to the challenge. ■

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